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ABSTRACT

A behavior therapy program was designed tc teach new coping skills to child abusing parents. Specific training procedures focused on child management techniques and subsequent sessions included training in communications skills, marital ccunseling and assertion training skills as required tc attain specified client goals. Training was carried out either in a clinic office or in the patient's home; these sites were compared to determine the cost-effectiveness of therapeutic gains made in either setting. Multiple measures of therapeutic change (behavicral and attitudinal) and problem reduction suggest two marked effects cf the program. First, in-home clients increased parenting skills twice as much (with duration of training held constant) as clients seen in the clinic office but trained using the same program. Second, positive shifts in attitudes toward children and parent role were 300 percent greater for the in-home clients. Cost data shows no advantage fcr either treatment site. (Author)

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BEHAVIOR THERAPY TREATMENT FOR CHILD ABUSE

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Child abuse has traditionally been thought of as an impulsive, unprovoked act. The abuse literature suggests that abusing parents lack skills needed in several areas of adult life (e.g., money management , communications skills, and child training and management). The project described in this paper has designed clinical interventions in a multifaceted, individualized program to teach a variety of skills to a population of abusing and potentially abusing parents. This report will focus on child management training.

The effects of skills training was only one of the project goals. A second was to examine the effects of working with parents either in a traditional office setting or in the family home. It was hypothesized that home training might be more cost-effective, especially as clients had to be more active to avoid keeping appointments, and also because many of our clients had transportation problems. The data presented today will report on two questions: (1) Can parents improve their child management skills?; (2) Is such training more effectively carried out in an office or in the home?

Subjects

Forty clients have completed the training program. Twenty-five were seen at the clinic and fifteen were seen in their homes. Of those seen at the clinic 68% were living with their mate, and 32% were single parents (mothers). Of those seen at home, 47% were with their mate; 53% were single parents. In-clinic clients were seen an average of 20.9 times and needed 6.7 months to terminate. At home clients were seen an average of 18.3 times and needed 6.5 months to terminate.

Assessment

In addition to the intake interview, clients fill out several questionnaires and surveys and completed a role-play assessment of parenting skills. Instruments include a children's behavior checklist, two surveys of parenting attitudes and beliefs, a profile of mood states and assertion inventory. On-going measures include goal attainment scaling, self-report monitoring of daily stress level, impulses to hit, and praise rate. Follow-up contacts assess frequency of use for each procedure, client statisfaction with the progress and recurring problems and use of other sources of assistance.

The pre-post role-play behavior assessment includes six common household situations presented one at a time. The client is asked to role play how he or she might react to such a situation in the home. The scenes include both appropriate and inappropriate child behavior: Fighting w/a sibling, compliance and non-compliance to a request, nagging for a cookie, a temper tantrum, playing quietly, and spontaneous performance of a household task. The parent is scored on the presence or absence of specific behaviors in each situation. Role playing gives both a quantitative and qualitative measure of parenting procedures. From the scoring the therapist can compute a percentage of appropriate parenting skills. The therapist can determine the excesses, deficits, and strengths of the parent and is also given some indication as to which children's behavior is particularly abrasive to the parent. It is on the basis of this role playing that the therapist determines which parental behaviors need to be added, eliminated or modified, and in which situations the behaviors need to be practiced.

Of the four child management procedures taught in this program, (praise, mild social disapproval: a brief, effective warning or reprimand, time out and ignoring) praise is always taught first. Praise is the most effective, and least expensive reinforcer at the parents' disposal. Parents generally have a variety of negative procedures in their behavioral repertoire, which they have used, albeit inconsistently, without much success. They frequently use little praise and expect a very high level of performance before giving praise. The seven components of effective praise are listed and modeled for the parent. These are: 1) eye contact; 2) proximity (the parent should be within three feet of the child; 3) a pleased facial expression; 4) verbal approval; 5) a non-verbal gesture of approval; 6) immediacy (the praise is to be delivered as soon as possible); and 7) praising the behavior rather than the child. As each component is listed, the therapist models both its presence and absence so that the parent is able to experience the effect of that component. For example, praise is given to the parent with eye contact and without eye contact in order that the parent may experience the increased meaning the communication carries when eye contact is included. Examples of verbal approval are modeled for the parent to encourage variety in the parent's expressions of approval. The therapist then models praise for the parent using the full sequence of behaviors and asks the client for feedback on performance. In order to determine what behavior to praise, parents are asked what behavior they would like to see their child perform more often. This is usually a difficult question for parents to answer, since their focus has been primarily on the child's negative behaviors, behaviors they would like to see the child perform less often. The positive behavior is then carefully defined, and the first role-play is conducted with the therapist taking the role of parent,

and the parent taking the role of child. The parent is asked to act as much like her child as possible. In this role-play the therapist models the steps she has explained. The roles are then reversed, and the parent delivers praise for the behavior previously defined. The parent is given feedback on her delivery of praise, while the therapist remembers that praise is her most effective reinforcer for the development of new behaviors. The scene is repeated and the client is again given feedback on her performance. Goals for the frequency of delivery of praise are negotiated with the client, and the client is given the homework assignment of recordings and practicing this predetermined rate of praise for the specific behavior. It is important that the frequency of delivery of reinforcement, and the criteria to be met by the child before being reinforced be set at attainable levels so that parent and child may both perceive themselves as achieving success.

The next procedure to be taught is determined by the initial role-playing, the children's behavior checklist (a list of 90 behaviors which the child has or has not performed in the past three months), and the parent's identification of the behavior over which they want most to gain control. If the child has a history of temper tantrums, time out will usually be taught at this point, since either mild social disapproval or ignoring may result in a temper tantrum. In teaching time out, the first step is to make the rule. The therapist role-plays a scene defining the offensive behavior, stating that in the future the child will be placed in time out for this behavior, showing the child the room where time out will be implemented, explaining the length of time (five, three, two quiet minutes), and the consequences for coming out before the time is up or for yelling, kicking, or banging on the door during time out. This explanation is made to the child in order to reduce the amount of interaction necessary when time out is actually carried out. The parent is then asked

to role-play this explanation with the therapist taking the child's role. the parent is given feedback on his/her performance and, if necessary, the role-playing is repeated. The components of time out are listed and explained for the client. They are: 1) State the rule ("That's a temper tantrum", "You're fighting"), 2) State the consequence ("Time out for five minutes."), 3) Stay calm (the role of the parent's behavior as model for the child is stressed) 4) Ignore all verbalizations ("I hate you", "I'll be good", "You don't love me") 5) Act immediately (Two reasons: It's easier to stay calm if you act within five seconds of the onset of behavior, and the child's behavior doesn't have time to escalate) 6) Following completion of the time out period, identify and praise appropriate behavior on the part of the child. Praise always follows a negative consequence so that the child can more quickly learn which behaviors earn their parents' approval. Praise also serves to restore the positve feelings the child has about him/herself and the positive feelings she/he has for the parent. The parent is instructed to record each occurance of the inappropriate behavior and also to record each delivery of time out, followed by praise. Besides providing information regarding progress of the procedure, the record keeping also serves as a prompt to the parent to engage in this new behavior.

Mild social disapproval is used to stop an inappropriate behavior or to facilitate compliance with parental requests. Its components are 1) brief verbal disapproval (brevity is stressed so that parents do not inadvertantly give rewarding attention to the behavior); 2) low intensity of delivery; 3) disapproving facial expression and/or non-verbal gesture of disapproval; 4) eye contact; 5) proximity; 6) immediacy; 7) praising appropriate behavior which follows: A behavior for which mild social disapproval is to be given

is chosen from the Children's Behavior checklist or from the parents verbal report. The sequence is role-played, with the therapist always taking the role of parent the first time. The roles are reversed and the parent delivers the mild social disapproval sequence. Feedback is given to the parent and the role-playing is repeated as often as necessary. Goals are negotiated regarding the delivery of mild social disapproval, and homework assignments are given. The homework assignments are discussed at the next meeting, and problems are dealt with by role-playing the problem situation with the parent immediately taking the role of herself. The therapist gives feedback and the role-playing is repeated with the therapist modeling the role of parent. The role-play is now repeated with the parent again taking the role of herself.

Ignoring is the procedure recommended for repeated, annoying, but non-destructive behaviors such as crying, whining, nagging, or other demands for attention. In ignoring, we try to eliminate all the behaviors that denote that attention is being paid to the child. We instruct the parent, therefore, to 1) look away from the child, 2) move away (at least three feet), 3) maintain an expressionless face, 4) ignore <u>all</u> verbalizations/vocalizations, 5) begin ignoring immediately after the onset of the behavior, and continue ignoring until the behavior has stopped. The parents are warned to expect the behavior to increase during the initial stages of ignoring. They are reassured that consistency in using ignoring for a specific behavior will definately result in a reduction or elimination of the behavior. When the child stops the inappropriate behavior, the parent is told to praise him/her for appropriate behavior. The same sequence of role-playing is followed: define the behavior to be ignored, therapist takes the role of parent, parent takes the role of parent, parent is given feedback, parent again takes the role of parent. Goals are negotiated and homework assigned.

Guided Practice

In the home, the presence of the child makes possible the direct observation of parent-child interactions. While the same procedures of explanation, demonstration and role-playing occur in treatment carried out in the home, it is also possible to engage in modeling with the child and in guided practice. The modeling procedure enables the parent to observe an in vivo interaction between the therapist and his/her child. The interaction is discussed with attention given to the various components. At the next opportunity, the parent is given guided practice in the same procedure. In guided practice, the therapist is able to prompt the parent to carry out the child management skills at appropriate times. The therapist is also able to coach the parent to deliver specific components of the child management procedures. For example, the parent may attempt to deliver mild social disapproval from across the room. The therapist will remind the parent that she needs to be closer to the child. The parent may attempt to ignore a child's demanding behavior while still looking at the child. The therapist is able to direct the parent to another part of the room, and to move with her, thereby shaping the parent's response. The presence of the child also enables the therapist to tailor the steps of the procedure to deal with this specific child, a process which facilitates the learning and effectiveness of the program.

Results

The project described is on-going and data is being collected in a number of areas. The results so far suggest preliminary answers to our two questions about child management training. 1) Can we demonstrate improvements in child management skills? Yes. Both groups more than doubled the number of component behaviors they exhibited from pre to post assessment. 2) Is such training more effectively carried out in the home

or in the office? With amount and duration of contact approximately equal, office-trained parents increased parenting skills by 155%, home-trained parents increased by 376%. Confidence in themselves as parents and favorable attitudes toward their children increased 13% in office-trained parents, while the same areas increased 41% in home-trained parents.

In this brief paper, it is not possible to go into the other areas also dealt with in the program. It must be remembered, however, that child management skills training does not occur in a vacuum. The training must be part of a package that also includes assertive communication training, stress management training and training in other life-coping skills. We have tried to provide a multi-faceted program to deal with the multi-faceted problem of child abuse.